Agenda Item 5a
08/07/08 Meeting

Highlights of Governor Schwarzenegger's Health Care Reform Proposal

Goal: Contain health care costs while improving access to high quality, cost-efficient and effective health care services.

ISSUES	METHODS
Minimum Loss Ratio (MLR)	• Establishes 85% MLR for health plans and insurers.
Health Care Cost and Quality Transparency (HCCQT)	• Ensures collection of, public access to and analysis/utilization of health care cost and quality data; Adds requirements about percutaneous coronary intervention data, which includes, but is not limited to, the use of angioplasty or stents. • Establishes HCCQT Committee to address related issues. • Requires HCCQT Committee to develop and implement a HCCQT plan which, if accepted by the Health and Human Services Secretary, will be implemented by the Secretary.
Electronic Health Records (EHRs), e-Medical Records (EMRs) and e-Prescriptions (e-Rx)	• Improves capacity of health plans, pharmacies and heath care providers/prescribers to use and/or transmit EHRs, EMRs and e-Rx. • Allows health plans and insurers ("carriers") to electronically notify consumers in defined circumstances including explanations of benefits, carriers' policies, contracting provider lists, specific rate changes, specific notices related to underwriting decisions and responses to subscribers' inquiries. • Requires prescribers to provide e-Rx receipts to consumer. • Collects and disseminates e-Rx best practice findings. • Requires all California licensed prescribers and pharmacies operating in California to have the ability to transmit and receive e-Rx.
Lower-Cost Health Care Delivery Systems	• Addresses Nurse Practitioners' scope of practice. • Allows Medi-Cal Managed Care Plans to avoid duplication in meeting both Department of Managed Health Care and Department of Health Care Services requirements. • Creates a CalPERS demonstration project enabling members to obtain workers' compensation

	care for injuries at the same health plans or insurers that provide the member with health care services.
Adverse Events (i.e., serious health care related events which should never occur)	• Improves monitoring of adverse events and disclosure of related data • Tasks newly created HCCQT Committee (see above) with developing non-billing and non-payment policies regarding adverse events, and requires MRMIB and Department of Health Care Services to implement related policies for their programs.
Medical Errors	• Reduces the incidence of healthcare-acquired infections, adverse drug reactions and surgical errors by requiring health care facilities to develop and implement patient safety plans.
Disease/Health Condition Prevention Coverage and Prevention Incentives	• Improves prevention benefits offered by health plans and insurers to public and private payors. • Requires health plans and insurers to offer Healthy Action Incentives and Rewards Program to improve access to and utilization of prevention and wellness services.
Oversight of Coverage Rescission, Cancellation and Individual Market Coverage	• Increases oversight of health plans and insurers regarding health coverage rescission and cancellation; Improves public reporting of related data. • Establishes standardized health plans' and insurers' medical underwriting application questions. • Defines standards under which a health plan or insurer may rescind or cancel coverage and standardizes a process for rescinding or canceling coverage, and for challenging rescissions. • Requires Department of Managed Health Care and California Department of Insurance to jointly develop regulations with standard benefit and cost-sharing definitions and terminology for individual market products, and requires the Office of the Patient Advocate (OPA) to produce a uniform benefits matrix, comparing products. The regulations may require health plans and insurers to submit information for definitions and terminology and for the OPA benefits matrix. • Requires all individual health policies to contain a maximum limit on out-of-pocket costs, including, but not limited to copayments, coinsurance and deductibles, for covered benefits.
Balance Billing	• Prohibits balance billing by non-contracted emergency care providers. • Establishes a process for setting interim payment rates for providers for post-stabilization services.

A SUMMARY OF THE LANGUAGE OF PHASE I HEALTH REFORM IN CALIFORNIA

By Ansony Kim, Rebecca Pizzitola, and Michael Sloyan

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Since January when AB X 1 1 did not pass the Senate Health Committee in California, both advocates and legislators have been working hard to devise a way to continue the effort to reform California's health care system. Based on an analysis of the pieces of AB X 1 1 and legislation currently in play, the Administration has chosen pieces that have broad support and potential to improve the health care system in California for a two-phase reform plan. In light of a budget crisis, the Administration has promoted budget-neutral options for the first phase, including specifically: 1) cost containment, 2) consumer protections, and 3) prevention. The initial legislation is summarized below. Please note that none of the Administration's language are yet numbered bills unless amending related bills, and are therefore referred to here as "proposals." The Administration is open to receiving and strongly encourages comments and discussion to build consensus on how to stay unified during reform.

COST CONTAINMENT

Transparency: Empowering Patients and Making Providers Accountable

Summary: Creates the California Health Care Cost and Quality Transparency Committee and the Health Care Cost and Quality Transparency Fund in the California Health and Human Services Agency to develop and review a health care cost and quality transparency plan, assisted by the Office of Statewide Health Planning and Development (OSHPD).

The Legislature wants California to assume a leadership role in improving performance and value in the health care system. By collecting, analyzing and reporting health care costs, quality, and outcomes, the Legislature intends to promote competition, identify appropriate health care utilizations, and improve the quality of health care services for all Californians. It will be financed by an increase in hospital fees.

Comment: This proposal is similar to much of the language in AB 2967 (Lieber), which focuses on cost and quality data reporting by the same, newly-created Committee and Fund. AB 2967 has received some criticism for creating a new bureaucracy since OSHPD exists and performs certain duties related to transparency. This proposal continues to create a new bureaucracy, but encourages it to work with OSHPD—without giving full responsibility for additional tasks to OSHPD. Both efforts towards transparency would improve quality, increase competition and lower overall prices by providing the best available data on price, quality and health outcomes. Consumers would know more precisely what they were getting for their money. Providers would know which services were most likely to facilitate better health outcomes, preventing misuse and duplication of services. In the end, information about utilization, prices, and quality would improve access to health care services, patient safety, and patient and population health statuses, and result in more effective and efficient care and cost savings throughout the health care system. Another related bill, SB 1300 (Corbett), would allow insurers to share price and quality information with their enrollees, furthering these outcomes.

Enhancing the Use of E-Prescribing
Summary: Sets requirements for e-prescribing systems.

Electronic prescribing (e-prescribing) involves the electronic transmission of a prescription from a doctor or other prescriber directly to a pharmacy, rather than through facsimile or by giving the patient the prescription to take to the pharmacy. This proposal would require that e-prescribing systems must: 1) meet specific requirements for data exchange, 2) allow real-time verification of eligibility of benefits, 3) comply with confidentiality and data security requirements, and 4) comply with state record retention and reporting requirements. Prescribers must offer patients a written receipt of the information transmitted electronically. All prescribers and pharmacies would be required to be able to send and receive electronic prescriptions by January 1, 2012, while all health plans with drug benefits would have to electronically share current formularies with enrollees and pharmacies by January 1, 2010. In addition, the Department of Health Care Services would be required to identify e-prescribing best practices and to pilot a program to enhance the use of e-prescribing for Medi-Cal providers, depending upon funding availability.

Comment: E-prescribing is a method of cost containment that has the potential to reduce medical errors, enhance patient compliance with treatment and reduce administrative costs. This proposal helps define what an e-prescribing system should look like and encourages its use. It pushes a small, but important, part of the growth of health information technology.

Spend More on Care, Not Administration: Increasing the Medical Loss Ratio (MLR)
Summary: Limits the amount of revenue to be spent on administrative purposes.

This proposal would require full service health care service plans and health insurers to spend at least 85% of the aggregate dues, fees, premiums, and other periodic payments they receive for their health plans on the covered health services.

Comment: Regulating the percentage of revenue that may be used for non-benefit purposes forces health insurers and health plans to focus more on health care spending than on profits, health plan executive salaries, broker commissions, and other non-benefit costs. This is a small but effective cost containment method that can enhance health plan efficiency and improve the quality of coverage. A related bill is SB 1440 (Kuehl).

Restructuring Nurse Practitioners' Scope of Practice
Summary: Redefines the scope of practice (permitted job tasks) for nurse practitioners.

This proposal would create the Task Force on Nurse Practitioner Scope of Practice that would consist of specified members appointed by the Governor, Assembly Speaker, and Senate Committee on Rules. The task force would be responsible for developing a recommended scope of practice for nurse practitioners and share it with the Governor and the Legislature on or before June 30, 2010.

Comment: Expanding nurse practitioners' scope of practice has been a topic of interest for the health care industry for some time. Advocates believe that nurse practitioners are capable of providing a leading role in the health care of patients with certain illnesses in place of medical doctors. Allowing nurse practitioners to perform tasks traditionally done by doctors could help

alleviate access problems in areas with doctor shortages and could help contain rising costs by allowing professionals who can deliver care at a lower cost per service than doctors to do so.

Electronic Personal Health Records
Summary: Creates electronic personal health records and provides for electronic communication between the provider or insurer and the patient/policyholder.

This proposal would authorize the Board of Administration of the Public Employees' Retirement System to provide or arrange for the provision of an electronic personal health record for their enrollees. This proposal would also allow a health care service plan or insurer to provide notices by electronic transmission and made available via the Internet if authorized by the patient and if meeting specific standards of interoperability, privacy, and data exchange.

Comment: Personal health records would be used to give patients access to information on benefits eligibility and cost-sharing requirements, and possibly information listed in their personal health records including laboratory tests, prescriptions, claims history, and other personal health information. Much of this information is already available upon request by patients, but this proposal would enhance the ability to share this information electronically. As such, this proposal is viewed as a cost containment method to improve quality through increased transparency, while simultaneously decreasing the amount of time and paperwork associated with paper-based health records and increasing the continuity of patient care among different providers and facilities.

CONSUMER PROTECTIONS

Eliminating Balance Billing for Emergency and Post-Stabilization Care
Summary: Prevents balance billing for emergency or post-stabilization care.

Current laws require insurers and plans to have mechanisms in place to resolve billing and claim disputes with non-contracting providers. For example, if an insured patient shows up for an emergency and gets care from a doctor who does not take his or her insurance, there must be a way to both reimburse the physician and protect the patient. This proposal expands that law by specifying that patients with insurance other than what a physician accepts cannot be billed for emergency or post-stabilization hospital-based services beyond their copayment or cost-sharing requirements (e.g., their coinsurance). Instead, non-contracting, hospital-based emergency room physicians must submit their billing dispute with the patient's health plan for independent resolution or take any other means they currently have available, short of billing the patient for the difference. Additionally, this proposal would establish an interim payment standard and independent resolution process for disputes to ensure doctors get proper and timely payment, similar to a current bill by Senator Don Perata's SB 981.

Comment: This piece of legislation would help protect Californians from balance billing abuses while strengthening efforts to ensure fair and prompt payment of claims to non-contracted providers. This proposal is similar to SB 981 (Perata), although it does not specify the interim payment standard and does not require providers to accept the lesser of a defined interim payment standard or their full charge; greater specificity may be needed. A related bill that prevents hospitals from balance billing patients for post-stabilization care is AB 1203 (Salas).

Medi-Cal Managed Care Surveys for Health Plans Serving Medi-Cal Beneficiaries
Summary: Surveys marketing practices, health insurance cards, and related products of a health insurer or health plan.

Health plans are currently subject to duplicative standards to ensure proper delivery of the health plan. This proposal would require health care service plans that provide services to beneficiaries covered under a Medi-Cal managed care program to be subject solely to the filing, reporting, monitoring, and survey requirements established by the State Department of Health Care Services for the Medi-Cal managed care program for designated subjects. (Designated subjects are advertising and marketing; member materials, including member handbooks, evidences of coverage, and disclosure forms; and product design, including its scope and limitations.) This proposal would require the Department of Managed Health Care (DMHC) and the State Department of Health Care Services to develop a joint filing and review process for specified medical quality surveys.

Comment: This proposal would reduce duplicative regulation and monitoring of health insurers' business practice related to marketing, informing, and disclosures related to Medi-Cal products.

Amending Rescission Language in the Knox-Keene Health Care Service Plan Act of 1975
Summary: Standardizes health coverage application forms and requires insurers to complete all medical underwriting before signing a contract with a subscriber.

This proposal would require health care service plans and health insurers to establish standard information and health history questions on their individual health insurance application forms. These forms would have to include clear and unambiguous information "reasonable and necessary" for underwriting purposes with a specific notice that HIV information is not required. Preexisting conditions' questions must be limited to a specific look-back period. By 2010, all applications would have to be reviewed and approved by the director of the DMHC before use by a health plan. This proposal would require all plans to complete medical underwriting (application investigation and approval) prior to issuing a health care service plan contract and to meet certain requirements with regards to medical underwriting; it would delete the prohibition of post-claims underwriting. The proposal would prohibit a plan from canceling or rescinding an individual's coverage unless the applicant willfully misrepresented his or her information prior to the contract, among other specified conditions including properly notifying the applicant of a potential rescission. Health plans would be required to annually report the total number of individual health care service plan contracts issued, canceled, or rescinded. The proposal would, beginning January 1, 2010, establish an independent review process to review health plan decisions to cancel or rescind health care service plan contracts.

Comment: Similar to the rescission language above, this proposal would prevent business practices related to unfair rescissions of individual health insurance policies for preexisting conditions that were allegedly inaccurately reported on applications or were misrepresented or omitted by a broker, solicitor or agent. This proposal would protect consumers from incurring exorbitant medical debt after losing coverage at the time of need based on a health plan's or insurer's claim that the condition to be treated was preexisting and not reported on one's application. Related legislation includes AB 1945 (De La Torre), which would create a third-party review process for rescissions including approval by the Department of Insurance (DOI) and DMHC and require standardized

application language. AB 2549 (Hayashi) would impose a six-month limit on an insurer's ability to rescind coverage.

Amending Rescission Insurance Codes
Summary: Prevents fraudulent rescissions.

This proposal would prevent "fraud, unfair trade practices, and economically unsound insurance" for policyholders of disability insurance. This proposal would ensure that the language of all insurance policies can be readily understood and interpreted; the DOI would not approve policies that are misleading or have certain payment, cancellation, benefits, and compensation schemes that are not of value to the insured. In addition, this proposal puts forward language mimicking that noted above—establishing standardized applications for insurance and medical underwriting rules and rescission policies.

Comment: This proposal represents an effort to prevent business practices regarding unfair rescissions of consumers' health insurance plans. It helps prevent consumers from misinterpreting the type of plan they are about to apply and pay for, and helps to ensure proper compensation and benefits are in place were they to become ill and need to use their coverage.

Tiering of Individual Market Products: Amendments to SB 1522 (Steinberg)
Summary: This proposal would categorize insurance policies into five categories.

This proposal will ensure that all individual health care service plan contracts issued, amended, or renewed on or after January 1, 2009 will contain a maximum limit on out-of-pocket costs for covered benefits (i.e., copayments, coinsurance, and deductibles). This proposal would require, on or before September 1, 2009, the DOI and DMHC to jointly develop standard definitions and terminology for benefits and cost-sharing provisions applicable to all health care service plan contracts and health insurance policies to be offered to individuals on and after July 1, 2010.

Comment: This is proposed as an amendment to SB 1522 (Steinberg), which would categorize health insurance plans in the individual market into five tiered groups ranging from "comprehensive" to "catastrophic", while defining minimum benefit standards. This bill and the Administration's proposed amendments would facilitate transparency and consumer comparison-shopping for health coverage, while establishing a minimum benefits package so as to protect consumers from purchasing "junk" insurance.

PREVENTION

Patient Safety Plan
Summary: Requires standardized safety measures to reduce preventable medical errors.

This proposal would require specified health facilities to develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable medical errors. At a minimum, this proposal would require the health facility to establish a patient safety committee, a reporting system for medical errors and near misses, and a process for providing patient safety training for facility personnel and health care practitioners.

Comment: This proposal would promote patient safety and reduce preventable and negligent medical errors, including hospital-acquired infections (HAIs), medication errors, and near misses, by enhancing reporting and training. Other bills working to prevent hospital-acquired infections include SB 158 (Florez) and SB 1058 (Alquist). All of these proposals and bills work to prevent illness, which subsequently can contain costs in the health care system.

Adverse Events: Amendments to AB 2146 (Feuer)
Summary: Defines certain adverse events and ensures that patients and purchasers of health care services would not be billed for substantiated adverse never events.

This legislation recognizes that most adverse events can be prevented through ongoing health care provider education and established safety procedures. This proposal would establish a committee to, no later than September 10, 2010, make initial recommendations to the secretary of California Health and Human Services for the implementation of non-billing and non-payment policies and practices for never events.

Comment: This legislation specifies amendments to AB 2146 (Feuer), which works to prevent "never events"—often the worst and most preventable type of medical errors. AB 2146 proposes nonpayment for "never events," following standards forwarded by Medicare. This proposal alters AB 2146 in many ways, including adding language to ensure follow-up care to correct "never events" is reimbursed and specifying error types (e.g., wrong limb surgery).

A 24-Hour Coverage Pilot: Linking Workers' Compensation to Group Health Insurance
Summary: Creates a pilot program aimed at improving the quality, continuity and access to health care for state employees.

This proposal pilots a program to improve workers' compensation for state employees. Specifically, this proposal seeks to streamline medical care covered by group health insurance with care covered through workers' compensation, with the aim of improving employer and employee satisfaction, timely access to care ("readily available and accessible at reasonable times"), medical outcomes, and the quality and continuity of care while reducing duplicative administrative costs. CalPERS would establish a 24-Hour Care Demonstration Program until January 1, 2014 to provide treatment to state employees enrolled in the employer's health benefit plan for occupational injuries or illnesses. Treatment would be provided through health service plans or insurers that currently provide non-occupational health care, making it "24-hour." There would be no employee cost-sharing for treatment of occupational injuries, and all communications between the health plan, the employer and the employee will keep non-occupational and occupational costs and descriptions distinct. A full evaluation of the pilot, would be conducted by an independent organization. No changes would be made to which conditions qualify for workers' compensation, and this pilot would not apply retroactively or to those without an employer health benefit plan.

Comment: This proposal works to improve care from the patient perspective, while also partially streamlining administration. Through this proposal, a single insurance company and their set of providers would be administering both non-occupational and occupational health services. This could cut administrative costs even though communications, including billing, for each type of service would remain distinct. The more likely outcome is that care would be more accessible,

satisfying, and coordinated for patients—though not seamless 24-hour coverage. As a pilot, the goal of this proposal is to experiment with and evaluate innovations to improve the system of care. If the experiment does not work, it will expire in 2014. If it does work, it could be extended.

Healthy Actions, Healthy Rewards: Encouraging Healthy Behaviors
Summary: Encourages CalPERS enrollees to be more engaged in their health.

This proposal would require that group health plans covering hospital, medical, or surgical expenses (except Medicare supplement plans) offer an approved Healthy Action Incentives and Rewards Program for its prospective and existing CalPERS enrollees by January 1, 2010. To avoid adverse selection, the plans would have to price their programs the same for enrollees regardless of the risk profile of the group, and could not make enrollment contingent upon acceptance into their program or design their programs based on this risk. A Healthy Action Incentives and Rewards Program would include risk appraisals for healthy and unhealthy behaviors (e.g., health screenings, immunizations and tobacco use), the review of risk appraisals with an appropriate health care provider, and possibly follow-up with a web-based tool or nurse hotline. Incentives could include cash payments or cost-sharing discounts (e.g., premiums); if a premium reduction is used, it must be a uniform discount for all groups and subscribers and only offered after the completion of a program or behavior. Rewards could include coverage for nontraditional services and products, such as gym memberships, weight management programs or over-the-counter pharmaceuticals.

Comment: This proposal aims to encourage CalPERS enrollees (public employees) to be more engaged in their health care and to practice healthy behaviors by cutting their financial costs (incentives) or giving them added benefits targeted to reducing their health risk profile (rewards). Assuming enrollees have the ability to practice healthy behaviors, motivating them to do so has the potential to cut health care costs by preventing the onset and exacerbation of acute and chronic disease. Spreading the risk and cost of programs that encourage healthy behaviors is key. This proposal attempts to do this while avoiding adverse selection—by requiring that pricing be the same to enroll regardless of health status. This proposal, however, does not mandate that everyone enroll in a program. This leaves the door open to pricing based on the assumption that only the chronically ill will enroll, particularly if cheaper plan options without Healthy Incentives and Rewards programs exist and the rewards and incentives are not enough to draw in healthier enrollees.